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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the delay should be explained in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12510

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12199

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN 1b 12 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mildred Middle May Last Akol				4. DATE OF DEATH Month 11 Day 6 Year 1961			
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-8-04	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY House keeping		11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Reidenback				14. MOTHER'S MAIDEN NAME Elizabeth			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Eugene A. Akol Chesapeake City Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ulcer of stomach with DUE TO (b) Arteriosclerosis General DUE TO (c) Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Chesapeake City		20g. (County) Cecil	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE R.C. Dodson CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) R.C. Dodson, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 11-6-61							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-9-61		22c. NAME OF CEMETERY OR CREMATORY Moravian Cemetery		22d. LOCATION (City, town, or country) (State) Lititz, Penna.	
23. FUNERAL DIRECTOR PIPPIN FUNERAL HOME				24. REC'D BY REGISTRAR Nov 9 '61			
24b. REGISTRAR'S SIGNATURE Arthur S. House							

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12511

12500

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 35 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Ohio b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cleveland d. STREET ADDRESS 4315 Denison Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CALVIN A. ALDER				4. DATE OF DEATH Month Day Year November 13 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 12-25-92			
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		11. BIRTHPLACE (County & State, or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Alder		14. MOTHER'S MAIDEN NAME Phoebe Pitts			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yea		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, severe DUE TO (b) Carcinoma of the right parotid gland with metastasis to lungs and ribs DUE TO (c) 1420 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that XXXXXX attended the deceased from December 11 1926 to November 13 1961 and that death occurred 12:35 am from the causes and on the date stated above.							
22a. SIGNATURE A. L. Mooney				22b. DATE SIGNED 11-16-61			
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md.				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 11/17/1961		23c. NAME OF CEMETERY OR CREMATORY Arlington			
23d. LOCATION (City, town or county) Arlington, Virginia		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE Arthur S. Kraus			
24. FUNERAL DIRECTOR'S SIGNATURE Bennington & Son, Havre de Grace, Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Journal of Management Studies, 1987, 20(6), 625-632

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FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>Don</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> d. STREET ADDRESS <u>Steels Motel</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Lonnie Franklin Anders</u>				4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1961</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>12-16-1903</u>		9. AGE (In years last birthday) <u>57</u> yrs. IF UNDER 1 YEAR: Months <u>10</u> Days <u>19</u> Hours <u>01</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Coal mining</u>				11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jasper Anders</u>				14. MOTHER'S MAIDEN NAME <u>Bertha McCann</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>236-09-0246</u>		17. INFORMANT <u>Hospital Records</u>		Address <u>Elkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage of Lungs</u> (b) <u>Silicosis</u> (c) <u>523.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>R.C. Dodson</u>				EXAMINER'S NAME (Type) <u>R.C. Dodson, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
								DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11-18-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>11-20-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Galex, Virginia</u>		22d. LOCATION (City, town, or country) <u>Elkton, Md.</u>		(State)	
23. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>				ADDRESS <u>Donald P. Pippin, Elkton, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 22 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

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FOR STATE
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TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12513

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12502

1. PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) PORT DEPOSIT c. LENGTH OF STAY IN 1b 11 MONTHS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ROUTE 222, PORT DEPOSIT, MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) PORT DEPOSIT d. STREET ADDRESS 204B LAFFEY CIRCLE PORT DEPOSIT MD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle EDWARD Last ANDERSON				4. DATE OF DEATH Month November Day 4 Year 19 61			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 August 1935	
9. AGE (In years last birthday) 26 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radioman		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Washington State	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Charles Anderson		14. MOTHER'S MAIDEN NAME Hazel Drew		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 7-30-54, 11-4-61	
16. SOCIAL SECURITY NO. 536 32 0144		17. INFORMANT U. S. Naval Service Record, Bainbridge, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) left tibia & fibula above ankle, Fracture right tibia & fibula & femur, Fracture right humerus, (b) Laceration left side of face & forehead, Laceration left wrist, Abrasions finger & face, Laceration right upper leg posteriorly. (c) right upper leg posteriorly. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Compound Fracture left tibia & fibula above ankle. Fractures Right tibia fibula & femur, right humerus.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Station Wagon ran off of road and hit a tree.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Station Wagon ran off of road and hit a tree.		20c. TIME OF INJURY Month, Day, Year 11-4-61 Hour 1:40 P.M. <input checked="" type="checkbox"/> A.M. <input type="checkbox"/>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. #222		20f. (City or town) Port Deposit, Cecil Md.		20g. (County) Cecil		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				21. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE R. C. DODSON EXAMINER'S NAME (Type) R. C. DODSON				DATE SIGNED 11-4-61 Address (Street, city, town, or county) Rising Sun, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11-6-1961		22c. NAME OF CEMETERY OR CREMATORY Fort Rosecrans National		22d. LOCATION (City, town, or country) (State) San Diego, 6, California.	
23. FUNERAL DIRECTOR See a. Patterson & Son,				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR NOV 7 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12514

12503

1. PLACE OF DEATH a. COUNTY <u>Cecil County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u> c. LENGTH OF STAY IN lb <u>15 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>VA Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Pittsburgh</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>75x-3</u> d. STREET ADDRESS <u>513 Campbell St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MICHAEL J. MY BOYLE</u>		4. DATE OF DEATH Month <u>11</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-9-90</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ireland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael J. Boyle</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Riedy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>VA Hospital Records-Perry Point, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331 X</u> IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (e), stating the underlying cause last. } DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>the VA</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>Dr. Dhia Allahverdi</u> attended the deceased from <u>7-18-46</u> , 19 <u> </u> , to <u>11-27-61</u> , 19 <u> </u> , and that death occurred <u>3:10 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Dhia Allahverdi</u>		22b. DATE SIGNED <u>11-27-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>DHIA ALLAHVERDI, M.D.</u>		22d. ADDRESS <u>VAH, Perry Point, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE THEREOF <u>11/28/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Pittsburgh, Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington & Son</u>		25a. REC'D BY REGISTRAR <u>NOV 30 '61</u>	
ADDRESS <u>Havre de Grace, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>	

M

A

1871

STATE OF OHIO

1871

County of Hamilton

Shirley

Shirley

1871

1871

Shirley

Shirley

1871

Shirley

Shirley

Shirley

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Shirley

Shirley

Shirley

Shirley

1871

1871

Pittsburgh, Pa.

Pittsburgh, Pa.

Nov 1871

Nov 1871

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

12515
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
12504

1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Childs				c. LENGTH OF STAY IN 1b 5 min.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS Ronowingo			
3. NAME OF DECEASED (Type or print) First Middle Last Kenneth Edward Brammer				4. DATE OF DEATH Month Day Year 11/ 22/ 19 61			
5. SEX M.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/22/1940	
9. AGE (In years last birthday) 20 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fork Lift Operator Cable Plant		11. BIRTHPLACE (State or foreign country) Md.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fork Lift Operator Cable Plant				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Clyde Brammer				14. MOTHER'S MAIDEN NAME Blanche Pyle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes				16. SOCIAL SECURITY NO. 219 38 5959			
17. INFORMANT Mrs. Blanche Brammer Conowingo Md.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound Fracture of both lower legs left arm DUE TO (b) and neck lacerations of face and nose. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car collided with tree			
20c. TIME OF INJURY Month, Day, Year 11 22 61 Hour 11:25 a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Route 1415			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Elkton Cecil Md.				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R.C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 11-23-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11/27/ 61			
22c. NAME OF CEMETERY OR CREMATORY Conowingo Cem.				22d. LOCATION (City, town, or country) (State) Conowingo Md.			
23. FUNERAL DIRECTOR Common E. McMullen				24a. REC'D BY REGISTRAR Rising Sun, Md.			
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				DATE NOV 27 '61			

MEDICAL CERTIFICATION



Childs

5 min.

Baronino

Enthal

Geoff

Geoff

Baronino

Edward

Kenneth

11/

22/

61

20

12/22/1910

W.

M.

York Last Operator Cable Plant

NY.

U.S.A.

Oliver Brainer

Blanche Fyle

219 38, 2029 Mrs. Blanche Brainer, Goppying, Md.

Compound fractured both lower legs last year

and neck I corrosion of face and nose.

Car collided with tree

x

Route 115

11 22 61

11-22

Milton

Geoff

Md.

x

x

x

Rising Sun, Md.

Rising Sun

11-23-01

of Goppying Com.

Rising Sun, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO VITAL RECORDS: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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65
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12516
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 18395
12516
MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY in 1b <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Union Hospital of Cecil County</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Rural R. D. 3 Elkton, Md.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>F.</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saw Mill work (general) Saw Mill</u>		9. AGE (In years last birthday) <u>57</u> yrs.	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James H. Brown</u>		14. MOTHER'S MAIDEN NAME <u>first-unknown Last- Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-10-8356</u>	
17. INFORMANT <u>Mrs. Lucy V. Brown, R. D. 3, Elkton, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Myocardial Infarction</u> <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>12 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 29, 1961</u> to <u>Nov. 29, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov. 29, 1961</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph G. Lanzi</u> 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED <u>Dec 14 '61</u>	
22d. ADDRESS <u>205 W. Main Street, Elkton, Md.</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 2, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Elkton, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 14 '61</u>	
ADDRESS <u>Elkton, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	



1931

[Faint, mostly illegible text, possibly a letter or document, with some handwritten notes.]

112
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

12517
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12505
Item 14 Film 0300 11/15/61 mb
MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY in 1b 8 years			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland			b. COUNTY Cecil			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton			d. STREET ADDRESS 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Middle Last Vernon C Brown			4. DATE OF DEATH Month Day Year Nov. 7 1961			5. SEX Male			6. COLOR OR RACE White			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH April 7, 1912			9. AGE (In years last birthday) 49 yrs.			IF UNDER 1 YEAR Months Days Hours Min.			IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Farm & Industry			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Vernon Brown			14. MOTHER'S MAIDEN NAME Della Anderson			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 219-16-5804			17. INFORMANT Mrs Ruth Ann Brown, Elkton, Md.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		INTERVAL BETWEEN ONSET AND DEATH 10min.											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation by Hanging 974X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO																													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Put rope around joint and around neck and stepped off chair																										
20c. TIME OF INJURY Month, Day, Year ? Hour a.m. p.m. 11-7 19 61			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) Elkton			(County) Cecil			(State) Maryland														
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE R.C. Dodson			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 11-8-1961														
EXAMINER'S NAME (Type) R.C. Dodson			Address (Street, city, town, or county)																										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 11-11-61			22c. NAME OF CEMETERY OR CREMATORY North East Methodist			22d. LOCATION (City, town, or country) (State) North East, Maryland.																				
23. FUNERAL DIRECTOR Joseph R. Grant			ADDRESS North East, Md.			24a. REC'D BY REGISTRAR DATE NOV 10 '61			24b. REGISTRAR'S SIGNATURE Arthur S. Krawe																				

MEDICAL CERTIFICATION

④



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12518

CERTIFICATE OF DEATH

Reg. Dist. No. 12506

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ellis W. Bullock				4. DATE OF DEATH Month Day Year Nov. 1, 19 61			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 10, 1883	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Leeds, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Miller W. Bullock				14. MOTHER'S MAIDEN NAME Sarah Jane Bullock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Atherosclerotic Heart Disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10-29, 1961, to 11-1, 1961, that I last saw the deceased alive on 11-1, 1961, and that death occurred at M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Tillman D. Johnson M.D.				ADDRESS (Street, city or town, state) 123 S. 17th St. Cecil County, Md.			
PHYSICIAN'S NAME (Type) Tillman D. Johnson M.D. Elkton, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11/5/61		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Cecil County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				ADDRESS Elkton, Maryland		24a. REC'D BY REGISTRAR DATE NOV 8 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

15718

CERTIFICATE OF DEATH

15718

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1900		New York City	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Catholic	
Date of Death		Time of Death		Place of Death		Physician		Burial Place	
Jan 15, 1945		10:30 AM		Home		Dr. Smith		Catholic Cemetery	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12519
12507
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE District of Columbia <input checked="" type="checkbox"/>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN lb 29 days		d. STREET ADDRESS 1846 Vernon Street, N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LEWIS (NMI) CARTER		4. DATE OF DEATH November 21 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-88
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 21 Days 21 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Not available	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Carter (deceased)		14. MOTHER'S MAIDEN NAME Charlotte Lyle (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lower nephron nephrosis, cause undetermined DUE TO (b) post-operative Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Right Lower Quadrant sinus tract and cellulitis of the abdominal wall DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. VA 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from October 23 1961 to Nov. 21 1961 , that (2) (we) saw the deceased alive 10:20 pm and that death occurred at 11-24-61 M, from the causes and on the date stated above.			
22a. SIGNATURE Stephen A. Hegedus		22b. DATE 11-24-61	
22c. PHYSICIAN'S NAME (Type) S. A. HEGEDUS		22d. ADDRESS V.A. Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 11/24/61		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		25a. REC'D BY REGISTRAR NOV 30 '61	
25b. REGISTRAR'S SIGNATURE Carley L. Kraus			

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Director of Columbia

Smith

Washington

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1945

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George Carter (Deceased)

Not available. Essential records, FBI, New York, N.Y.

Not available. Essential records, FBI, New York, N.Y.

Not available. Essential records, FBI, New York, N.Y.

Not available. Essential records, FBI, New York, N.Y.

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CERTIFICATE OF DEATH

Reg. Dist. No. **12508****12520**

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 12 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Carty		4. DATE OF DEATH Month Nov. Day 9 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1876
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 85 Days 85 Hours 85 Min.	11. IF UNDER 24 HRS. Months 85 Days 85 Hours 85 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Turner		14. MOTHER'S MAIDEN NAME Georgianna Kirby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Marguerite Potts, Elkton, Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease with congestive heart failure 422.1 DUE TO (b) Obesity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 30, 1961 to November 9, 1961 , that I last saw the deceased alive on November 8, 1961 , and that death occurred at 5 p. M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 233 E. Main Street DATE SIGNED 11/11/61	
ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D.		PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR., M.D. Elkton Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12/61	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Bethel, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		24a. REC'D BY REGISTRAR NOV 29 '61	
ADDRESS Elkton, Md.		24b. REGISTRAR'S SIGNATURE Charles L. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No. 12509

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RISING SUN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NORVAL First MILLARD Middle COALE Last		4. DATE OF DEATH NOV. Month 20 Day 1961 Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 9, 1904
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLASTERER		10b. KIND OF BUSINESS OR INDUSTRY CONTRACTOR	11. BIRTHPLACE (State or foreign country) PHILADELPHIA, PA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME SAMUEL T. COALE	
14. MOTHER'S MAIDEN NAME CLARA HINDMAN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 216-07-8801		INFORMANT Address OLIVE COALE, RISING SUN, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331X DUE TO hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) alcoholism DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 wks.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/2 , 19 61 , to 11/20 , 19 61 , that I last saw the deceased alive on 11/20 , 19 61 , and that death occurred at 110 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun, Md DATE SIGNED 11/21/61 ACTUAL SIGNATURE Neil Taylor Jr M.D. PHYSICIAN'S NAME (Type) Neil Taylor Jr MD Rising Sun, Md 11/21/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/24/61	22c. NAME OF CEMETERY OR CREMATORY Brookview Cemetery	22d. LOCATION (City, town, or county) (State) Rising Sun, Md
23. FUNERAL DIRECTOR'S SIGNATURE Ralph M. Reed, Rising Sun, Md.		24a. REC'D BY REGISTRAR DATE NOV 24 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1930

DEPARTMENT OF HEALTH

1931

[Faint, mostly illegible text, likely a form or record, possibly containing names and dates.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12522

12510

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Queen Annes	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grasonville,	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VA Hospital		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) First Thomas Middle H. Last Collier		4. DATE OF DEATH Month Nov Day 4 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-20-76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 85 yrs.
11. BIRTHPLACE (County & State, or foreign country) Grasonville Md		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Henry Collier		14. MOTHER'S MAIDEN NAME Rachel Harney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes SAW - WW I		16. SOCIAL SECURITY NO. NONE -	
17. INFORMANT VA Hospital Records - Perry Point, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 420-0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Chr. Congestive Heart Failure (c) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 4-7 Days Weeks Months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7-14-60 , 19 60 , to 11-4-61 , 19 61 , and that death occurred at 5:15AM from the causes and on the date stated above.			
22a. SIGNATURE A.L. Mooney M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 11/4/61	
22c. PHYSICIAN'S NAME (Type) A.L. MOONEY, Clin. Pathologist		22d. ADDRESS VAH., Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 11/4/61	
23c. NAME OF CEMETERY OR CREMATORY Stevensville		23d. LOCATION (City, town or county) (State) Stevensville Md	
24. FUNERAL DIRECTOR'S SIGNATURE W. Lawrence Becton		ADDRESS Becton Ben C. Becton	
25a. REC'D BY REGISTRAR NOV 9 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

(M)

13523

13510

Scott

Marshall

Goodman

Forty Point

17, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

VA Hospital

Hono

Collier

H.

Thompson

Male

White

2-20-76

Unknown

U. S. A.

Yes

SA - W. I.

VA Hospital Records - Forty Point, Hawaii

Arteriosclerotic Heart Disease

1-7 Days

Cor. Congestive Heart Failure

Weeks

Arteriosclerotic Heart Disease

Months

Coronary Artery Disease

IX

1-1-60

11-4-61

11/4/61

VA, Forty Point, HI

W. I. HONOLULU, Oahu, for studies

11/4/61

Removal

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12523

12511

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point 12 days c. LENGTH OF STAY IN lb 12 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VA Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE New Jersey Gloucester b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clayton d. STREET ADDRESS 334 S. Delsey Drive 67X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John E. Collins			4. DATE OF DEATH Month Nov Day 4 Year 19 61				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 2-13-99		9. AGE (In years last birthday) 62 yrs. IF UNDER 1 YEAR: Months 8 Days 21 Hours Min. 		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Weaver			
11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John E. Collins			14. MOTHER'S MAIDEN NAME Elizabeth Johnson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 142 09 6692		17. INFORMANT VA Hospital Records - Perry Point, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral 5-27-1 DUE TO Pulmonary Emphysema, severe Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Gastric Ulcer - 2 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that 10-23 (this hospital) attended the deceased from 10-23 to 11-4 , 19 61 10:30 A.M. and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE A. L. MOONEY		22b. DATE SIGNED 11 4 61		22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D. Asst. Clinical Pathologist			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 11/6/61		23c. NAME OF CEMETERY OR CREMATORY Beverly National			
24. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SON FUNERAL HOME - Havre De Grace, Md.		25a. REC'D BY REGISTRAR NOV 9 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

(M)

1973

1971

Case

Forty Point

VA Hospital

John

M.

Collins

Nov

of

Male

Never

John H. Collins

Age

Age 50

VA Hospital Records - Forty Point, Maryland

Pneumonia, bilateral

Pulmonary tuberculosis, severe

Chronic obstructive

2 years

x

12-13

11-11

A. J. KIMBLE, M.D., Chief, VA Hospital - Forty Point, Maryland

Severely ill, Nov 1971

WASHINGTON & SON Funeral Home - Prince Georges, Md.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 9/60

MEDICAL CERTIFICATION

<div> <div>12525</div> <div> <div>12513</div> <div>12/18/61</div> </div> </div> <div> <div> <div>12525</div> <div>12513</div> </div> <div> <div>12525</div> <div>12513</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital D.O.A.</u>						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East Rural</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>William W Foreacre</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 23, 1881</u> 9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						4. DATE OF DEATH <u>Nov. 8 1961</u> Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Joseph Foreacre</u> 14. MOTHER'S MAIDEN NAME <u>unknown Woodrow</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mrs. Mary J. Foreacre, North East, Md.</u> Address <u>RD</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Acute Coronary</u> DUE TO (b) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						20c. TIME OF INJURY Month, Day, Year <u>8</u> <u>11-8</u> <u>1961</u> Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>R.C. Dodson</u> M.D. EXAMINER'S NAME (Type) <u>R.C. Dodson</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>11-8-1961</u> Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>11-12-61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u> 22d. LOCATION (City, town, or country) (State) <u>North East (Rural) Md.</u>						23. FUNERAL DIRECTOR <u>Joseph R. Grant</u> ADDRESS <u>North East, Maryland.</u> 24a. REC'D BY REGISTRAR <u>NOV 10 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Grant</u>					

1943

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1943

STATE OF NEW YORK
COUNTY OF NEW YORK



Form with various fields for medical examination and death certification, including checkboxes and text areas. The form is partially obscured by a large, dark, diagonal mark.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12520
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12514

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN,			
d. NAME OF HOSPITAL (If not in hospital, give street address) UNION HOSPITAL				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ALICE MATILDA GARVIN				4. DATE OF DEATH Month Day Year 11/ 8/ 1961			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/10/1885		9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRESSMAKER RET.		10b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMINE B. GARVIN				14. MOTHER'S MAIDEN NAME SUSAN R. FERGUSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 212-20-8320A		17. INFORMANT Miss ANNA GARVIN Address RISING SUN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction DUE TO (c) Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 week Unknown Unknown							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-25 1961 to 11-8 1961 , that (I) (we) last saw the deceased alive on 11-7 1961 , and that death occurred at 10AM , from the causes and on the date stated above.							
22a. SIGNATURE Williford Eppes				22b. ADDRESS Hillside & Dallam Rds Newark, Del		22c. DATE SIGNED NOV 13 '61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/11/1961		23c. NAME OF CEMETERY OR CREMATORY BROOKVIEW CEM.	
24. FUNERAL DIRECTOR'S SIGNATURE Thomas E. McMillen				25a. REC'D BY REGISTRAR NOV 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

12345

UNITED STATES OF AMERICA

12345

(M)

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NO.

12345

WASHINGTON, D.C.

3 DAYS

12345

HOSPITAL

12345

12345

GARVIN

12345

12345

1/10/1988

12345

U.S.A.

NO.

SELF-EMPLOYED

12345

SUSAN R. WILSON

BENJAMINE B. GARVIN

WASHINGTON, D.C.

12345-20-83304 MISS ANN GARVIN

NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12527

12515

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 1yr.7mo.20days X Rising Sun	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES L. GORRELL		4. DATE OF DEATH Month November Day 20 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-11-90
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. BIRTHPLACE (County & State, or foreign country) Maryland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Gorrell		14. MOTHER'S MAIDEN NAME Evelyn Nesbitt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. 212-12-4104 unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized. Gangrene, right foot. Chronic INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II and in 18.) Brain Syndrome	
20c. TIME OF INJURY Month, Day, Year Hour a.m. VA 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that JAMES L. GORRELL attended the deceased from March 31, 1960 , to Nov. 20, 1961 and that death occurred at 1:45 pm on the causes and on the date stated above.			
22a. SIGNATURE S. Goldgraben		22b. DATE SIGNED 11-20-61	
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, Chief, Medical Service, VAH, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/23/1961	
23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cemetery		23d. LOCATION (City, town or county) (State) Calver, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Ralph Reed		25a. REC'D BY REGISTRAR NOV 24 '61	
24. FUNERAL HOME Ralph Reed Funeral Home, Rising Sun, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. House	

12-15

12-15

M

November 10 1961

VI

9-11-60

White

Joseph G. Smith

Joseph G. Smith

Medical Records, 100, Perry Street, N.Y.

Medical Records

W-1

Yes

Arteriosclerotic heart disease with myocardial

infarction

Arteriosclerotic heart disease, right bundle branch block

Arteriosclerotic heart disease

XXXXXXXXXX 100 Nov 30 1961

XXXXXXXXXX 100 Nov 30 1961

11-30-61

Medical Records, 100, Perry Street, N.Y.

Medical Records, 100, Perry Street, N.Y.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12528

12516

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural		c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Chester Middle John Last Hall				4. DATE OF DEATH Month 11 / Day 29 / Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/24/1886		9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator Ret. Fiber Mill			10b. KIND OF BUSINESS OR INDUSTRY Md.		11. BIRTHPLACE (State or foreign country) U.S.A.		
13. FATHER'S NAME William Hall				14. MOTHER'S MAIDEN NAME Susan Davidson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 221-07-8256		17. INFORMANT Mr. Paul Hall		Address Rising Sun, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Atherosclerosis DUE TO and Hypertension (c) 							INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 2 19 61 , to Nov 29 19 61 , that (I) (we) last saw the deceased alive on Nov 23 19 61 , and that death occurred at 3:30 from the causes and on the date stated above.							
22a. SIGNATURE <i>G.H. Richards Jr.</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/1/61	
22c. PHYSICIAN'S NAME (Type) G.H. Richards Jr.				22d. ADDRESS Post Office Box 1, Rising Sun, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/2/1961		23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.		23d. LOCATION (City, town, or county) (State) Colora Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Coman E. McMillen</i>				25a. REC'D BY REGISTRAR DEC 4 '61		25b. REGISTRAR'S SIGNATURE <i>Charles S. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

8581

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

12529
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12517

1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural North East				c. LENGTH OF STAY IN 1b Lifetime				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural North East			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George W. Hamilton				4. DATE OF DEATH Month November				Day 13			
5. SEX male				6. COLOR OR RACE white				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 12-16-1878				9. AGE (In years last birthday) 82 yrs.				IF UNDER 1 YEAR Months 82			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auditor and High School Teacher				10b. KIND OF BUSINESS OR INDUSTRY Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME J. Wesley Hamilton				14. MOTHER'S MAIDEN NAME Ann Maria Mullen				Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 221-03-7666				17. INFORMANT G. Page Hamilton			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				INTERVAL BETWEEN ONSET AND DEATH 5 min Years				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 11-4-1961 Rising Sun Md Address (Street, city, town, or county)				ACTUAL SIGNATURE R.C. Dodson EXAMINER'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 11-6-1961 22c. NAME OF CEMETERY OR CREMATORY Methodist 22d. LOCATION (City, town, or county) North East Cecil Co., Md				23. FUNERAL DIRECTOR Joseph R Grant ADDRESS North East Md 24a. REC'D BY REGISTRAR NOV 9 '61 24b. REGISTRAR'S SIGNATURE Carlton S. Kline			

451

5481

12530

CERTIFICATE OF DEATH

Reg. Dist. No. 12518

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Delaware b. COUNTY New Castle ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington 46X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 1344 Reed Street	
3. NAME OF DECEASED (Type or print) First James Middle A. Last Howell		4. DATE OF DEATH Nov. 25, 1961 Month Day Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1902
9. AGE (In years lost birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator		10b. KIND OF BUSINESS OR INDUSTRY Delaware	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME No record		14. MOTHER'S MAIDEN NAME No record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW 2		16. SOCIAL SECURITY NO. 222-09-4315	
17. INFORMANT A.W. Howell		Address Christiana, Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic coronary narrowing (c) Generalized atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH 24 hours unk unk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-25, 1961, to 11-25, 1961, that I last saw the deceased alive on 11-25, 1961, and that death occurred at 10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Williford Epps M.D.		ADDRESS (Street, city or town, state) Dallam Rd. DATE SIGNED 11/27/61	
PHYSICIAN'S NAME (Type) Williford Epps		Newark, Delaware	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 29, 1961	22c. NAME OF CEMETERY OR CREMATORY Bethel Cem.	22d. LOCATION (City, town, or county) (State) Bethel, Md.
23. FUNERAL DIRECTOR'S SIGNATURE K. T. Jones ADDRESS Newark, Del.		24a. REC'D BY REGISTRAR DATE DEC 5 '61	24b. REGISTRAR'S SIGNATURE Arthur L. Plante

CERTIFICATE OF DEATH

1923

1923

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES J. JONES		Male		35		1888		Maryland		Baltimore		Maryland		United States	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
Salesman		Heart Disease		Natural		Several Months		April 1923		Baltimore		Maryland		United States	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S BIRTH		MOTHER'S BIRTH		FATHER'S DEATH		MOTHER'S DEATH	
John J. Jones		Mary J. Jones		Salesman		Homemaker		1850		1860		1900		1910	
EDUCATION		RELIGION		MARRIAGE		CHILDREN		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE	
High School		Roman Catholic		Married		3		1910		Baltimore		Maryland		United States	
DATE OF INTERVIEW		INTERVIEWER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
April 1923		J. J. Jones		J. J. Jones		J. J. Jones		April 1923		Baltimore		Maryland		United States	

RECEIVED

STATE DEPARTMENT OF HEALTH - BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
12531 item 9 Film G302 12/18/61 iwk										
CERTIFICATE OF DEATH										
Reg. Dist. No. 12519										
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RD #1 Elkton					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Elkton					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital					d. STREET ADDRESS 1 RD #1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Anna Middle F. Last Johnson					4. DATE OF DEATH Month Nov Day 23 Year 1961					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-11-10		9. AGE (In years last birthday) 51 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Oak Grove, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lucas Kelley					14. MOTHER'S MAIDEN NAME Maude Towers					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address George B. Johnson RD #1 Elkton			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175.0 Intestinal obstruction DUE TO (b) Metastatic Carcinoma DUE TO (c) Carcinoma, ovary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None									INTERVAL BETWEEN ONSET AND DEATH 14 d. 6 mos 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1961, to 11-23, 1961, that I last saw the deceased alive on 11-23, 1961, and that death occurred at 6:32 PM, from the causes and on the date stated above.										
ACTUAL SIGNATURE Tillman D. Johnson M.D.					ADDRESS (Street, city or town, state) 123 S. 1st Ave. DATE SIGNED 11-23-61					
PHYSICIAN'S NAME (Type) Tillman D. Johnson MD Elkton Md										
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					22b. DATE THEREOF 11-27-61		22c. NAME OF CEMETERY OR CREMATORY RIVERVIEW CEMETERY		22d. LOCATION (City, town, or county) (State) WILMINGTON, DEL.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Herbert M. Harrington - Wilmi., Del.					24a. REC'D BY REGISTRAR DATE NOV 29 '61		24b. REGISTRAR'S SIGNATURE Curious & House			

15218

15218

(M)

Herbert M. Harrington
c/o Marshall N. Yeatman & Son,
Funeral Directors
819 Washington St.
Wilmington 1, Del.

Hicks & Son Home.

Anne L. Johnson

11/23/61

Cecil Co.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12532

CERTIFICATE OF DEATH

12520

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural		c. LENGTH OF STAY IN life Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cokesbury				d. STREET ADDRESS Cokesbury		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle B. Last Kell				4. DATE OF DEATH Month Nov. 19, Day 19 Year 61			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 23, 1884	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min. 7		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME John T. Brown				14. MOTHER'S MAIDEN NAME Mary E. Hawkins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If gave or defers of service)			
17. INFORMANT Alice Jones, Port Deposit, Md.				Address Rural			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Sclerosis 334X DUE TO Cerebral Sclerosis Conditions, if any, which gave rise to immediate cause (b) Cerebral Sclerosis (c) Cerebral Sclerosis DUE TO Cerebral Sclerosis cause last.				INTERVAL BETWEEN ONSET AND DEATH 4 yrs - 7 yrs -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1955 to Nov. 18, 1961 ; that (I) (we) last saw the deceased alive on Nov-18-61 , and that death occurred at 12:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Clarence I. Benson M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Nov-20-61	
22c. PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.				22d. ADDRESS Port Deposit, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-22-1961		23c. NAME OF CEMETERY OR CREMATORY Cokesbury Cemetery		23d. LOCATION (City, town or county) (State) Port Deposit, Md. Rural	
24. FUNERAL DIRECTOR'S SIGNATURE Veera. Patterson & Son,				ADDRESS Perryville, Md.		25a. REC'D BY REGISTRAR NOV 24 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12533
CERTIFICATE OF DEATH
12521

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 146 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 104 N. Cresson Street	
3. NAME OF DECEASED (Type or print) BERNARD M. LACHNER		4. DATE OF DEATH Month Day Year November 23 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/12/99
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Lachner (deceased)		14. MOTHER'S MAIDEN NAME Annie Cylander (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT VA Records, VAH, Perry Point, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis generalized severe		INTERVAL BETWEEN ONSET AND DEATH 4-5 days unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that XXXXXX attended the deceased from 6/30 to 11/23 , 19 61 and that death occurred on 11/23 at 9:15 PM from the causes and on the date stated above.			
22a. SIGNATURE J. L. Garey		22b. DATE SIGNED 11/24/61	
22c. PHYSICIAN'S NAME (Type) J. L. GAREY, Clinical Pathologist		22d. ADDRESS VAH, Perry Point, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/28/1961	
23c. NAME OF CEMETERY OR CREMATORY Natl. Cem., Baltimore, Md.		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Bennington & Son		25a. REC'D BY REGISTRAR NOV 30 '61	
ADDRESS Havre de Grace, Md.		25b. REGISTRAR'S SIGNATURE Charles S. K...	

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noted.

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References

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• *Phylogeny*

V.A. Rozhnova, V.V. Kozlov / Journal of Great Lakes Research 38 (2012) 69–76

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12534

CERTIFICATE OF DEATH

Reg. Dist. 12522

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EIKTON</u>		c. LENGTH OF STAY IN 1b <u>2 WEEKS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JEANIE</u> First Middle Last <u>LANE</u>		4. DATE OF DEATH Month <u>11</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/5/1911</u>
9. AGE (In years lost birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Willie Glasgow</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>LOUIS LANE</u> Address <u>PERRYVILLE, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>EDEMA OF LUNGS & VISCERA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL VASCULAR ACCIDENT</u> (c) <u>HYPERTENSIVE ARTERIOSCLEROTIC DISEASE 10 YEARS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>10 MINUTES</u> <u>2 WEEKS</u> <u>10 YEARS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/23, 1961</u> to <u>11/5, 1961</u> that I last saw the deceased alive on <u>11/5, 1961</u> , and that death occurred at <u>6 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Randall Ross</u> M.D.		ADDRESS (Street, city or town, state) <u>201 E. MAIN ST</u> DATE SIGNED <u>11/5/61</u>	
PHYSICIAN'S NAME (Type) <u>J. RANDALL ROSS, M.D.</u>		<u>EIKTON, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/7/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAND CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ASHLAND VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Nicky</u> ADDRESS <u>EIKTON, MD</u>		24a. REC'D BY REGISTRAR <u>NOV 8 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

STATE AND COUNTY OF NEW YORK

4681

12535

CERTIFICATE OF DEATH

Reg. Dis. No. 12523

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 21 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES WHITING MARLOW SR.		4. DATE OF DEATH November 4, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1881
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Govt.		10b. KIND OF BUSINESS OR INDUSTRY Maratime	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Luke Marlow		14. MOTHER'S MAIDEN NAME No Info.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles W. Marlow, Jr. Wilm. Del.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Bilateral Bronchopneumonia (b) Acute Bacterial U.R.T. (c) DUE TO CONDITIONS, IF ANY, WHICH gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Heart Disease, Chronic Bronchitis		INTERVAL BETWEEN ONSET AND DEATH 3 weeks - 1 week?	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/16, 1961, to 11/4, 1961, that I lost saw the deceased alive on 11/6, 1961, and that death occurred at 3:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter Stavakis		ADDRESS (Street, city or town, state) 154 W. MAIN	
PHYSICIAN'S NAME (Type) PETER STAVAKIS M.D.		DATE SIGNED 11/6/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 7, 1961	
22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME 104 W. Main St. Elkton, Md.		24a. REC'D BY REGISTRAR DATE NOV 9 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 from birth certificate

CERTIFICATE OF DEATH

Reg. Dist. No. 18524

12536

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Delaware b. COUNTY New Castle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Glasgow	
c. LENGTH OF STAY IN lb 20 Hrs.		d. STREET ADDRESS XXX Briggs Mobile Homes XXXXXXXXXX	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jodi Middle Lynne Last Mc Nair		4. DATE OF DEATH Month Nov. Day 14, Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1961
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min. 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXXXXXX		10b. KIND OF BUSINESS OR INDUSTRY XXXXXXXXXXXX	
11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joe Michael Mc Nair		14. MOTHER'S MAIDEN NAME Judith Ellen Van Keuren	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Joe M. Mc Nair, Glasgow, Del.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 760.0 DUE TO Acute respiratory failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral anoxia DUE TO (c) Subarachnoid hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 12 hours, 22 hours, ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/13, 1961, to 11/14, 1961, that I last saw the deceased alive on 11/14, 1961, and that death occurred at 9:35 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter Stavakis		M.D. ELKTON Md. DATE 11/15/61	
PHYSICIAN'S NAME (Type) Peter Stavakis, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-17-61	22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Pk.	22d. LOCATION (City, town, or county) (State) Nr. Elkton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME Donald W. Pippin Elkton, Md.		24a. REC'D BY REGISTRAR DATE NOV 20 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18781

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed by the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Princeton 67X-3			
c. LENGTH OF STAY IN 1b DOA				d. STREET ADDRESS 327 Jefferson Road			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital of Cecil County							
3. NAME OF DECEASED (Type or print) First Middle Last Milo William Mosser				4. DATE OF DEATH November 21 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-2-1890	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired carpenter				10b. KIND OF BUSINESS OR INDUSTRY carpentry			
11. BIRTHPLACE (State or foreign country) Penna.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Joseph Mosser				14. MOTHER'S MAIDEN NAME Caroline Stroup			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 139-20-0230			
17. INFORMANT Mrs. Milo W. Mosser				Address 327 Jefferson Rd, Princeton, N.J.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 20 Acute Coronary Occlusion Conditions, if any, which gave rise to immediate cause (b) General Arteriosclerosis (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 5 min. 15 yrs.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Dr. R. C. Dodson M.D. EXAMINER'S NAME (Type) Dr. R. C. Dodson CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 11/21/61 Address (Street, city, town, or county) Rising Sun, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/25/61		22c. NAME OF CEMETERY OR CREMATORY LAWN CROFT		22d. LOCATION (City, town, or county) (State) BOOTHWYN, DEL. CO. PENNA.	
23. FUNERAL DIRECTOR ADDRESS PIPPIN FUNERAL HOME - Donagh. 2200 E. 14th St. Md.				24a. REC'D BY REGISTRAR NOV 22 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

MEDICAL CERTIFICATION

UNITED STATES
DEPARTMENT OF HEALTH



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12538

12526

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Port Deposit c. LENGTH OF STAY IN 1b 15 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mt. Ararat Farms		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural d. STREET ADDRESS Mt. Ararat Farms e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Ann Middle Celyne Last Mott		4. DATE OF DEATH Month Nov. Day 24 Year 19 61				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1917	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days 44 yrs.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Albert Ramson		14. MOTHER'S MAIDEN NAME Sarah Lukens		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. 186-07-2407		17. INFORMANT Frederick B. Mott, Port Deposit, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Generalized Arteriosclerosis DUE TO (c) hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 6-21 , 19 61 , to 11-24 , 19 61 , that (I) (we) last saw the deceased alive on 11-23 , 19 61 , and that death occurred at 2 A.M. , from the causes and on the date stated above.						
22a. SIGNATURE G.H. Richards Jr.		22b. DATE SIGNED 11/24/61		22c. PHYSICIAN'S NAME (Type) G.H. Richards Jr. M.D.		
22d. ADDRESS Port Deposit, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				
23b. DATE THEREOF 11-27-1961		23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		23d. LOCATION (City, town or county) (State) Port Deposit, Md. Rural		
24. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson, Son,		ADDRESS Perryville, Md		25a. REC'D BY REGISTRAR NOV 28 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hume

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Post Office at Port Deposit, Md.

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CERTIFICATE OF DEATH

Reg. Dist. No.

12527

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Cecil		o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Elkton		X Rising Sun	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
Union Hospital		/	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last		Month Day Year	
Carl D. Muller		Nov. 14 1961	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
male	white		5/30/1899
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
62 yrs.		Commercial Artist	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Philadelphia, Pa.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Daniel Muller		Elizabeth Muhe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		216 03 4612	
17. INFORMANT		Address	
Robert C. Muller		44 Chippendale Circle, Newark, Delaware	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 345X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>complications of multiple sclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 wks. 12 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/15, 1961, to 11/14, 1961, that I last saw the deceased alive on 11/13, 1961, and that death occurred at 10A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Neil Taylor Jr.		Rising Sun, Md. 11/14/61	
PHYSICIAN'S NAME (Type)		Rising Sun Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		11/18/1961	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Moreland Memorial Park		Balto. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co.		24a. REC'D BY REGISTRAR DATE NOV 17 1961	
ADDRESS 4905 York Road Baltimore 12, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

#1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12540

12528

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY in 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital				e. STREET ADDRESS 324 W. Main Street,			
3. NAME OF DECEASED (Type or print) KYLE MULLINS				4. DATE OF DEATH Month Nov. Day 4, Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 11, 1938	
9. AGE (In years last birthday) 22 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Paynesville, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Harvey Mullins				14. MOTHER'S MAIDEN NAME Viola Blankenship			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 220-34-6807			
17. INFORMANT Wm. H. Mullins, Elkton, Md.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Fractures Skull and neck 819X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO						INTERVAL BETWEEN ONSET AND DEATH 5 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Car turned over after cutting off of telephone Pole			
20c. TIME OF INJURY Month, Day, Year 3:00 P.M. 11/4/61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 274		20f. (City or town) (County) (State) North East R.D. Cecil Co., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R. C. Dodson, M.D.				DATE SIGNED 11-5-61			
EXAMINER'S NAME (Type) R. C. Dodson, M.D.				DEPUTY MEDICAL EXAMINER Rising Sun, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-8-61		22c. NAME OF CEMETERY OR CREMATORY Vance Cemetery		22d. LOCATION (City, town, or country) (State) Paynesville, W. Va.	
23. FUNERAL DIRECTOR PIPPIN FUNERAL HOME				24a. REC'D BY REGISTRAR Nov 9 '61			
ADDRESS Elkton, Md.				24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

12328

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Name of Deceased		Date of Death	
John Doe		12-1-1912	
Place of Death		City of New York	
Cause of Death		Heart Disease	
Age		45	
Sex		Male	
Occupation		Teacher	
Residence		123 Main St, New York	
Signature of Physician		[Signature]	
Signature of Coroner		[Signature]	
Signature of Medical Examiner		[Signature]	

Name of Deceased		Date of Death	
John Doe		12-1-1912	
Place of Death		City of New York	
Cause of Death		Heart Disease	
Age		45	
Sex		Male	
Occupation		Teacher	
Residence		123 Main St, New York	
Signature of Physician		[Signature]	
Signature of Coroner		[Signature]	
Signature of Medical Examiner		[Signature]	

CERTIFICATE OF DEATH

Reg. Dis. 18529

12541

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bohemia Manor</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bohemia Manor, near Chesapeake City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bohemia Manor, near Chesapeake City</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Nuble</u> Last <u>Nuble</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 3, 1876</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Minor Washington</u>		14. MOTHER'S MAIDEN NAME <u>Kate-?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>213-01-1164</u>	
17. INFORMANT <u>Lola Nuble, Bohemia Manor, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia with cerebral thrombosis</u> 446X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Neprosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u> years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>senility</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 25</u> , 19 <u>61</u> to <u>Nov 27</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>27 Nov</u> , 19 <u>61</u> , and that death occurred at <u>2AM</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wallace Obenshain</u>		ADDRESS (Street, city or town, state) <u>Cecilton, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Wallace Obenshain, M.D.</u>		DATE SIGNED <u>28 Nov 61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/2/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bohemia Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edna R. Bell</u>		24a. REC'D BY REGISTRAR <u>NOV 30 '61</u>	
ADDRESS <u>Wilm. 409 Poplar St. Del.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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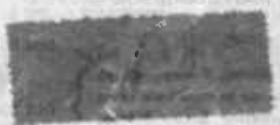
VS. A15ME
3M 9/60

Division of
12542

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rt. 274		c. LENGTH OF STAY IN 1b Instant		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North East, Md.		d. STREET ADDRESS 214 E. Main Street,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William		First Riley		Middle Payne	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH June 12, 1936		9. AGE (In years last birthday) 25 yrs.		10. IF UNDER 1 YEAR Months 25 Days 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		12. KIND OF BUSINESS OR INDUSTRY Automobile		13. BIRTHPLACE (State or foreign country) Paynesville, W. Va.	
14. FATHER'S NAME Irvin Payne		15. MOTHER'S MAIDEN NAME Rhoda Mullins		16. CITIZEN OF WHAT COUNTRY? U.S.A.	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) U.S. ARMY		18. SOCIAL SECURITY NO. 236-54-6684		19. INFORMANT Mrs. Ella Jane Payne, Elkton, Md.	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broken Neck and crushed body DUE TO (b) Car turned over after cutting off Telephone Pole DUE TO (c) Car turned over after cutting off Telephone Pole		21. INTERVAL BETWEEN ONSET AND DEATH 5 mins.		22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Car turned over after cutting off Telephone Pole	
23. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car turned over after cutting off Telephone Pole		25. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
26. TIME OF INJURY Month, Day, Year 3:00 P.M. 11-4-61		27. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> el work <input checked="" type="checkbox"/>		28. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 274 North East R.D. Cecil Co., Md.	
29. CITY OR TOWN Elkton		30. (City or town) Elkton		31. (County) Cecil	
32. (State) Md.		33. (State) Md.		34. (State) Md.	
35. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		36. CHIEF MEDICAL EXAMINER R.C. DODSON, MD.		37. DATE SIGNED 11-5-61	
38. EXAMINER'S NAME (Type) R.C. DODSON, MD.		39. RISING SUN, MD. Rising Sun, Md.		40. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
41. BURIAL, CREMATION, REMOVAL (Specify) Burial		42. DATE THEREOF 11-8-61		43. NAME OF CEMETERY OR CREMATORY Payne Cemetery	
44. LOCATION (City, town, or country) Paynesville, W. Va.		45. (State) W. Va.		46. REC'D BY REGISTRAR NOV 9 '61	
47. REGISTRAR'S SIGNATURE Arthur S. Kraus		48. (State) W. Va.		49. (State) W. Va.	

DATE OF DEATH
PLACE OF DEATH

1. Name of Deceased
2. Sex
3. Age
4. Race
5. Occupation
6. Cause of Death
7. Date of Death
8. Place of Death
9. Signature of Medical Examiner
10. Signature of Coroner



11. Signature of Medical Examiner
12. Signature of Coroner
13. Date of Death
14. Place of Death
15. Signature of Medical Examiner
16. Signature of Coroner

12543

CERTIFICATE OF DEATH

Reg. Dist. No. 12531

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN lb <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>CLINTON</u> Last <u>PENSEL</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>19.</u> Year <u>19 61</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10, 1879</u>	9. AGE (In years last birthday) yrs. <u>82</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (State or foreign country) <u>Warwick, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clinton Lynch</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Caldwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT Address <u>Henry J. Pensel, Chesapeake City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIO VASCULAR RENAL DISEASE</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>40</u> , to <u>NOV. 19</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>NOV 19</u> , 19 <u>61</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>CHESAPEAKE CITY MD 11/19/61</u>							
ACTUAL SIGNATURE <u>Henry J. Davis MD</u>		M.D.					
PHYSICIAN'S NAME (Type) <u>HENRY J. DAVIS MD</u>		<u>CHESAPEAKE CITY MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-22-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Chesapeake City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u>				ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 22 61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1854

1854

1854

(M)

12544

CERTIFICATE OF DEATH

Reg. Dist. No. 12532

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 6 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City	
3. NAME OF DECEASED (Type or print) First William Middle H. Last Pyle		4. DATE OF DEATH Month November Day 18 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1883
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisherman		10b. KIND OF BUSINESS OR INDUSTRY Fish	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William C. Pyle		14. MOTHER'S MAIDEN NAME Agnes Potridge	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT George Pyle		Address Chesapeake City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Mesenteric Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Atherosclerosis (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 3 days years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 13 Nov , 19 61 , to 18 Nov , 19 61 , that I last saw the deceased alive on 18 Nov , 19 61 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cecilton, Md. DATE SIGNED 2/ Nov 61 ACTUAL SIGNATURE Wallace Obenshain M.D. PHYSICIAN'S NAME (Type) Wallace Obenshain Cecilton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 22, 1961	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR DATE NOV 22 '61	
ADDRESS Elkton, Md.		24b. REGISTRAR'S SIGNATURE Clinton S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12544

CENTRAL CASE OF 1941

12544

(M)

U. S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C.

MEMORANDUM FOR THE DIRECTOR
FROM: SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

[The main body of the document contains several paragraphs of text that are extremely faint and illegible due to the quality of the scan. The text appears to be a memorandum or report, but the specific details cannot be discerned.]

CERTIFICATE OF DEATH

Reg. Dist. No. 12533

12545

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN		c. LENGTH OF STAY IN 1b 73 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CURTIS SPENCER REYNOLDS		4. DATE OF DEATH NOVEMBER 15 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1888
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY GENERAL PAINTING	
11. BIRTHPLACE (State or foreign country) RISING SUN, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE C. REYNOLDS		14. MOTHER'S MAIDEN NAME LAURA SPENCER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) W.W.I.		16. SOCIAL SECURITY NO. 220-07-4998	
17. INFORMANT Mrs Mildred Tifford, Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary aneurysm 420.1 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 wks. 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/15 , 19 61 , to 11/15 , 19 61 , that I last saw the deceased alive on 11/10 , 19 61 , and that death occurred at 8 A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Rising Sun, Md.	
ACTUAL SIGNATURE Neil R. Taylor M.D.		DATE SIGNED 11/16/61	
PHYSICIAN'S NAME (Type) Neil R. Taylor Jr. M.D.		ADDRESS Rising Sun, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/18/1961	
22c. NAME OF CEMETERY OR CREMATORY Brookview Cemetery		22d. LOCATION (City, town, or county) (State) Rising Sun, Cecil Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph M Reed		ADDRESS Rising Sun, Md.	
24. REC'D BY REGISTRAR Nov 20 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
12546 12534											
1. PLACE OF DEATH a. COUNTY CECIL MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE MD. b. COUNTY CECIL					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton						c. LENGTH OF STAY IN b D.O.A.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Ho spital						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN					
3. NAME OF DECEASED (Type or print) First Middle Last WALTER HERBERT REYNOLDS						4. DATE OF DEATH Month Day Year 11/ 22/ 1961					
5. SEX M.		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/ 9/ 1939		9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator Cable Plant						11. BIRTHPLACE (State or foreign country) Md.					
10b. KIND OF BUSINESS OR INDUSTRY						12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Horace J. Reynolds						14. MOTHER'S MAIDEN NAME Ruby Johnson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 219 36 0872					
17. INFORMANT Paula E. Reynolds						Address Rising Sun, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracturem of right fibula and Tibia compounded 823 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of neckabrasion both legs left side of (a), stating the underlying cause last. DUE TO forehead Laceration of scalp 2 1/2 in long and 1 1/2 in long. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Car wrecked and he was hit a tree.					
20c. TIME OF INJURY Month, Day, Year Hour, m. 11 22 61						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work Route 145					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Elkton R.D. Cecil Md.						20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Ale Dodson M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) R.C. Dodson						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF 11/26/ 61					
22c. NAME OF CEMETERY OR CREMATORY Brookview Cem.						22d. LOCATION (City, town, or country) (State) Rising Sun Md.					
23. FUNERAL DIRECTOR Armon E. McMullen						24a. REC'D BY REGISTRAR Rising Sun Md.					
24b. REGISTRAR'S SIGNATURE Armon E. McMullen						DATE NOV 27 '61					



STATE OF NEW YORK
IN SENATE
JANUARY 12, 1932

JOHN ELLISON

Union Ho Spital

WALTER

HENRY

RAYMOND

1/9/1932

U.S.A.

Machine Operator Cable Plant

Horace J. Reynolds
Luby Johnson

219 30 0872 Paula E. Reynolds Rising Sun, Md.

Fracture of right tibia and tibia compound

Fracture of neck of scapula both left side of

Forehead laceration of scalp 2 1/2 in long and 1 in long.

Man wrecked and he was hit a tree.

11 22 01

x Route 445

Ellison E.D. Cecil

Rising Sun X.D.

11-03-01

11-03-01

Prospect

Rising Sun, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
TICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12525

1. PLACE OF DEATH a. COUNTY CECIL		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b 5 Mo.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VAH., Perry Point, Md.		d. STREET ADDRESS 2426 -N Street, N.W.	
3. NAME OF DECEASED (Type or print) Fructuoso RIVERA		4. DATE OF DEATH Nov. 10, 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-21-24	
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Asherton, Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bicente Rivera		14. MOTHER'S MAIDEN NAME Marie Mendez	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Korean		16. SOCIAL SECURITY NO. 457-44-7890	
17. INFORMANT V.A. Hospital Records-Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation 929.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Accidental Drowning DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Caught foot in board over ditch & fell and unable to raise head out of water			
20c. TIME OF INJURY Month, Day, Year Hour e.m. - 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. S. DODSON		M.D. 11/10/61	
EXAMINER'S NAME (Type) R. S. Dodson		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county) Rising Sun, Md.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11/11/61	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or country) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR NOV 20 1961	
24b. REGISTRAR'S SIGNATURE Anthony J. Hanna			

VS. A15ME
5M 9/60

FOR STATE
HEALTH DEPT.



1938

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, and medical findings.

may be joined by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12548

CERTIFICATE OF DEATH

Reg. Dist. No. 12536

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union</u>				d. STREET ADDRESS <u>1 RD#5</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>EARL</u> Middle <u>S</u> Last <u>ROARK</u>				4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/6/01</u>	
9. AGE (In years lost birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemical Plant</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>William M. Roark</u>				14. MOTHER'S MAIDEN NAME <u>Cordelia Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>091-01-8702</u>			
17. INFORMANT <u>Mrs Virginia L. Roark</u>				Address <u>Elkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>502.0</u> DUE TO <u>Coronary Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic pulmonary emphysema</u> DUE TO <u>8-10 years</u> (c) <u>Chronic Bronchitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary sarcoid bilateral in 1954-1956</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2-3 weeks</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/2</u> , 19 <u>54</u> , to <u>11/2</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>11/2</u> , 19 <u>61</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Peter Stank</u>				ADDRESS (Street, city or town, state) <u>134 W. MAIN</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>PETER STANK M.D.</u>				LOCATION (City, town, or county) (State) <u>Elkton Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/6/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Park, Elkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>				ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 8 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Quinn S. Kline</u>							

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PERIODICALLY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
12549
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12537

1. PLACE OF DEATH o. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		c. LENGTH OF STAY IN 1b <i>2 mo.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hosp.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elk Mills X Rural</i>	
4. DATE OF DEATH (Type or print) <i>Winfield Schly Simp</i> First Middle Last		4. DATE OF DEATH Month <i>11</i> Day <i>19</i> Year <i>1961</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 25 1901</i>
9. AGE (In years last birthday) <i>59</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Paper Mill</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>George Simp</i>		14. MOTHER'S MAIDEN NAME <i>Annie Seth</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>221-07-9008</i>	
17. INFORMANT <i>Miss Hanna Simp</i>		Address <i>Elk Mills Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Tubercle's Endocarditis</i> 5811 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic pyelonephritis</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>August 1961</i> to <i>11-19</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>11-19</i> 19 <i>61</i> , and that death occurred at <i>2 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>William D. Johnson</i> M.D.		22b. DATE SIGNED <i>11-20-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>William D. Johnson MD</i>		22d. ADDRESS <i>123 Singlerly Ave. Elkton Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11-24-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cherry Hill Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Cherry Hill Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm E. McMillen</i>		25a. REC'D BY REGISTRAR <i>Rising Sun, Md.</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur E. Kline</i>		DATE <i>NOV 22 '61</i>	

15237

CERTIFICATE OF DEATH

15237

(M)

I hereby certify that on the 11th day of May 1901
 at the City of New York
 I have signed the following Certificate of Death
 in accordance with the provisions of the Act
 in that behalf passed by the Legislature of the State of New York
 in the year 1900.
 My hand and the seal of the Department of Health
 this 11th day of May 1901.
 Commissioner of Health
 John W. Allen
 Secretary of the Department of Health
 John W. Allen

CERTIFICATE OF DEATH

Reg. Dist. No. 12538

12550

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN lb 27 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Regina First M Middle Last Spann		4. DATE OF DEATH Nov. 4 19 61	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1867
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas McEnnis		14. MOTHER'S MAIDEN NAME Margaret Hennesey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
INFORMANT Address Miss Margaret Spann, North East, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular failure 422.1 DUE TO Bilateral pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. G.A.S., A.S.C.V.D. DUE TO (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 30 min. 3 days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility, Cerebral Art. Sclerosis, Gen. Chr. Rh. Arthrit.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-12-19 58 to 11-4-19 61 that I last saw the deceased alive on 11-3-19 61 and that death occurred at 8:20 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Luis M. Cuza		ADDRESS (Street, city or town, state) Cecil Ave., North East, Md.	
PHYSICIAN'S NAME (Type) Luis M. Cuza, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-7-61	
22c. NAME OF CEMETERY OR CREMATORY Immaculate Conception		22d. LOCATION (City, town, or county) (State) Elkton Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		24a. REC'D BY REGISTRAR North East, Maryland	
24b. REGISTRAR'S SIGNATURE		DATE NOV 9 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1918

DEPARTMENT OF HEALTH

15210

M

[Faint, mostly illegible text, likely a medical or administrative form. Some legible fragments include:]

NAME: _____

AGE: _____

SEX: _____

DATE: _____

PLACE: _____

REMARKS: _____

SIGNATURE: _____

DATE: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO VITAL REGISTRAR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12551 CERTIFICATE OF DEATH 12539

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Betterton	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS —	
3. NAME OF DECEASED (Type or print) First Middle Last LESLIE (NMI) VICKROY		4. DATE OF DEATH Month Day Year November 22 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-6-91
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days 14 X 2	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Not available		14. MOTHER'S MAIDEN NAME Rose Kirby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-I None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 162-1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Bronchogenic carcinoma right upper lobe of lung unknown (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6-7 days			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (XXXXXX) attended the deceased from Sept. 1, 1961 to Nov. 22, 1961 and that death occurred 8:20 AM from the causes and on the date stated above.			
22a. SIGNATURE A.L. Mooney		22b. DATE SIGNED 11-22-61	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/25/61	
23c. NAME OF CEMETERY OR CREMATORY Still Pond		23d. LOCATION (City, town or county) (State) Still Pond, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Kennedy Funeral Home, Still Pond, Md.		25a. REC'D BY REGISTRAR DATE NOV 27 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

15551

15551

(M)

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Not available
Name
Date
Place
Occupation
Address
City
State
Country
Remarks
11-1-11

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12552

CERTIFICATE OF DEATH

Reg. Dist. No. 12540

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EIKTON</u>		c. LENGTH OF STAY IN 1b <u>68 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EIKTON</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION-EIKTON, MD.</u>				d. STREET ADDRESS <u>149 BOLLINGSWORTH MAR.</u>			
3. NAME OF DECEASED (Type or print) First <u>FRANKLIN</u> Middle <u>TAYLOR</u> Last <u>WILLIAMS</u> SR.				4. DATE OF DEATH Month <u>11</u> Day <u>17</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/5/1893</u>		9. AGE (In years lost birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PAPER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES WILLIAMS</u>				14. MOTHER'S MAIDEN NAME <u>MARY MASON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>214-01-0389</u>		INFORMANT Address <u>DAVID K. WILLIAMS CHERRY HILL, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>IRREVERSIBLE HEART & EVIDENCE OF MYOCLONIC</u> <u>217X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>PERI LEPTIC ARREST</u> (c) <u>TUMOR RIGHT MIDDLE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS.</u> <u>UNKNOWN</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BILATERAL AUDIOPHOSIS; AORTIC STENOSIS; DIABETES MELLITUS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/10</u> , 19 <u>61</u> , to <u>11/17</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>11/17</u> , 19 <u>61</u> , and that death occurred at <u>7 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Randall Ross</u> M.D.				ADDRESS (Street, city or town, state) <u>201 E. MAIN ST. EIKTON, MD.</u>		DATE SIGNED <u>11/17/61</u>	
PHYSICIAN'S NAME (Type) <u>J. RANDALL ROSS M.D.</u>				<u>EIKTON, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/20/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WEST NOTTINGHAM</u>		22d. LOCATION (City, town, or county) (State) <u>WEST NOTTINGHAM, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u>				ADDRESS <u>DOVER, MD.</u>		24a. REC'D BY REGISTRAR <u>NOV 22 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. L. H. H.</u>			

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